

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 724

06600

1454 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 75 Years
 Hospital, institution, or street address where death occurred:
Allegany County Infirmary
 How long in hospital or institution? 2 Months 20 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Allegany County Infirmary
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mary Elizabeth Allee

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife William T. Allee
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) April 3, 1861
 8. AGE: Years 85 Months 5 Days 17 If less than one day _____ hrs. _____ min.
 9. Birthplace Indianapolis, Indiana
 (Town, county, and state)
 10. Usual occupation House
 11. Industry or business tt
 12. Name Iseral Jukes
 13. Birthplace England
 14. Maiden name Mary Timmons
 15. Birthplace England

16. Informant Miss Helen M. Allee
 Address 505. Frederick St, Cumberland, Md.
 17. Burial Date thereof 7/23/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Cumberland, Md.
 18. Funeral director William H. Kight
 Address Cumberland, Md.

19. July 23, 46 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20, 1946 10-20 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-26-46 to 7-20-46and that I last saw him alive on July 16, 1946Immediate cause of death Chronic myocardial regeneration DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations NoneDate of op. NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

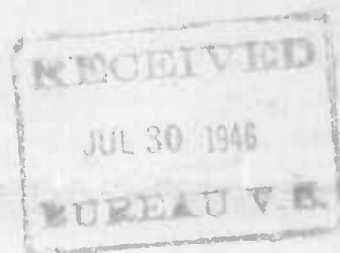
Means of injury _____ Injured at work?

23. SIGNATURE J. P. Franklin M.D. or otherAddress Cumberland Date signed 7/20/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186-2

07462

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND, M. RYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. 505 WASHINGTON ST.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

LILLIAN AMICK

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALEWHITEWIDOWED6. (b) Name of husband or wife Arthur Hammond Amick

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 10, 18558. AGE: Years 91 Months 5 Days 10 If less than one day hrs. min.9. Birthplace PA. Selins Grove
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name JOHN M. SMITH13. Birthplace PA.14. Maiden name ELIZABETH SCHOGH15. Birthplace PA16. Informant A. Hammond AmickAddress 505 Washington St. City17. Burial Date thereof July 22, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemLocation Cumberland, Md.18. Funeral director Chas. L. GeorgeAddress Cumberland, Md.19. July 22, 1946 J. P. Franklin, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20, 1946 at 46 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 24, 1946 to July 20, 1946and that I last saw him alive on July 19, 1946Immediate cause of death Semi-late

DURATION

Due to Fractured hipDue to Accidental fall, in bedroom at her home, Quaker

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of March 24, 1946

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) at homeMeans of injury fall Injured at work?23. SIGNATURE W. A. Mason

M. D. or other

Address Cumberland, Md. Date signed July 22, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 30 1946

BUREAU V E

Within corporate limits

Durvell

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1862

07464

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 1 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 101 Park St.
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME Luther Ash 3. (b) Social Security Number None

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced single

8. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) October 31, 1858 6. (c) If alive, give age _____ years

8. AGE: Years 87 Months 8 Days 6 If less than one day _____ hrs. _____ min.

9. Birthplace Flintstone, Allegany, Md.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Retail merchant.

12. Name Amos Ash

13. Birthplace Allegany Co. Md.

14. Maiden name Emily William

15. Birthplace Allegany Co. Md.

16. Informant Mrs. Minnie Patterson

Address 101 Park St. Cumberland, Md.

17. Burial Date thereof July 10, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hoffer

Address Cumberland, Md.

19. July 10, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 1946 at 11:07 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3, 1946 to July 7, 1946 and that I last saw him alive on July 6, 1946.

Immediate cause of death Coronary Thrombosis DURATION _____

Due to Fractured Left Hip

Due to Accidental fall, aged.

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of June 25, 1946

Where did injury occur? at her residence (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) at home

Means of injury falls Injured at work?

Clayton D. Sures

23. SIGNATURE Cumberland M.D. or other July 8, 1946
Address _____ Date signed _____

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 16 1946

BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 85-2

CERTIFICATE OF DEATH

Reg. Dist. No. 06601 4

1. PLACE OF DEATH:

County... Allegany
 City or town... Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 years
 Hospital, institution, or street address where death occurred:
Sylvan Retreat
 How long in hospital or institution? 12 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Allegany
 City or town... Little Orleans
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2. (a) If veteran, name war... None

3. (a) FULL NAME

Edward Barnes

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

✓

6. (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.)

July 14, 1879

8. AGE:

Years

Months

Days

It less than one day

67015

hrs.

min.

9. Birthplace

Fulton County, Penna.
(Town, county, and state)

10. Usual occupation

laborer

11. Industry or business

Railroad

MOTHER FATHER

12. Name

Charles Barnes

13. Birthplace

Fulton Co., Penna.

14. Maiden name

Jane A. Bishop

15. Birthplace

Fulton Co., Penna.

16. Informant

Mrs. Viola Price

Address

Little Orleans, Maryland

17.

(Burial, cremation, or removal, Which?)

Date thereof

July 31 1946
(month) (day) (year)

Cemetery or crematory

Allegany County Cemetery

Location

Cumberland, Maryland

18. Funeral director

John J. Hafer

Address

Cumberland, Md.

19.

July 31, 1946
(date rec'd by registrar)J. P. Franklin, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... July 29 1946, at 12:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 27, 1934 to July 29, 1946
and that I last saw him alive on July 29, 1946

Immediate cause of death

DURATION

Cerebral Hemorrhage

Due to

Due to

Other conditions

(Include pregnancy within months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. P. Franklin
Cumberland
Date signed 7-31-46

RECEIVED
AUG 2 1946
BUREAU V.S.

DR WILSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06602

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County... ALLEGANYCity or town... CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 HOURS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 9 HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... PA. County... BedfordCity or town... BEDFORD PA.
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

RANDALL BODDY

3. (b) Social Security Number

None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>MALE</u>	<u>BLACK</u>	<u>CHILD</u>

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 12, 1943

8. AGE:	Years	Months	Days	If less than one day
<u># 3 YEARS</u>	<u>0</u>	<u>9</u>	<u>hrs.</u>	<u>min.</u>

9. Birthplace... BEDFORD PA.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name... DONALD BODDY13. Birthplace... PA.14. Maiden name... MAXINE JOHNSON15. Birthplace... PA.16. Informant... MEMORIAL HOSPITALAddress... CUMBERLAND, MD17. Burial Date thereof... 7-24-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... EverettLocation... Everett Pa.18. Funeral director... Paul P. GalambosAddress... Everett Pa.19. July 23, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 21, 1946, at 12:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

20 July 1946 to 21 July 1946and that I last saw him alive on 21 July 1946

Immediate cause of death

Intestinal Obstruction

DURATION

Due to Intestinal AdhesionsDue to post-operative appendicitis

Other condition

(Include pregnancy within 8 months of death)

Major findings of operations... Intestinal Obstruction
+ adhesions

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Guller B. Whitworth

M. D. or other

Address... 112 Bedford St. Date signed... 21 July 46

MARGIN RESERVED FOR BINDING

VS A15-1 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 30 1946

BUREAU VS

#6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 Hrs.
 Hospital, institution, or street address where death occurred:

Allegany Hospital
 How long in hospital or institution? 12 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia County Mineral

City or town Ridgeley
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 10 Wabash Street
 (If rural, give LOCATION)

2. (a) If veteran, name war. ☒

3. (a) FULL NAME

CLARA MAY BOOTMAN

3. (b) Social Security Number

none

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Thos. A. Bootman6. (c) If alive, give age 67 years7. Birth date of deceased (mo., day, yr.) Dec. 30, 1886

8. AGE: Years 59 Months 6 Days 22 If less than one day
hrs.min.

9. Birthplace Ellerslie, Md.
 (Town, county, and state)

10. Usual occupation Housewife11. Industry or business Home12. Name David S. Barncord13. Birthplace Md.14. Maiden name Pauline Stein15. Birthplace Md.16. Informant Thomas A. BootmanAddress Ridgeley, W. Va.

17. Burial Date thereof July 24, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Luke Cem.Location Cumberland18. Funeral director Louis Stein, Inc.Address Cumberland

19. July 24, 1946 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 19 46, at 2:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21 19 46, to July 22 19 46, and that I last saw him alive on July 21 19 46.

Immediate cause of death Coronary Thrombosis DURATION 1 day

Due to.....

Due to.....

Other conditions Diabetic Mellitus

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. M. Schneider M. D. or otherAddress 411 E. 1st St. Date signed July 23/1946Cumberland, Md.

RECEIVED
JUL 30 1946
BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-a

CERTIFICATE OF DEATH

Reg. Dist. No. 4

06604

1. PLACE OF DEATH:

County Allegany
City or town Crestland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia County MineralCity or town Ridgely
(If outside city or town limits, write RURAL and give nearest town)Street No. 7 St. Patrick Ave
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Charles M. Brooks

3. (b) Social Security Number

705-12-20734. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Rose Alice Harlitz
7. Birth date of deceased (mo., day, yr.) April 21, 1891 6. (c) If alive, give age 54 years8. AGE: Years 55 Months 2 Days 23 If less than one day
hrs. min.9. Birthplace Myersdale Pa.
(Town, county, and state)10. Usual occupation Electrician11. Industry or business Western Ind. Shops12. Name James Brooks13. Birthplace Myersdale Pa.14. Maiden name Louise Albright15. Birthplace Myersdale Pa.16. Informant Mrs. Charles BrooksAddress Ridgely W. Va.17. Buried Date thereof 7/8/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Union CemeteryLocation Myersdale, Pa.18. Funeral director Harvey H. ZeiglerAddress Hyattsville Pa.19. July 8, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1946, at 9:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
June 1 1946 to July 5 1946
and that I last saw him alive on July 5 1946Immediate cause of death Uremia DURATION weeksDue to Hypertension C.V. Renal 2 yearsDue to Uremia

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Blane M. Schindler M. D. or otherAddress 41 E. ... Date signed July 8 1946

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 16 1946

BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170-2

CERTIFICATE OF DEATH

Reg. Dist. No. 066054

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 yrs

Hospital, institution, or street address where death occurred

318 Cecelia St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 318 Cecelia St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William Alexander Brown

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male white single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 15, 1945

8. AGE: Years Months Days It less than one day

4 3 2 hrs. min.9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Arthur C Brown13. Birthplace Maryland14. Maiden name Laura Gollack15. Birthplace Maryland16. Informant Arthur C BrownAddress Cumberland, Md.17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/20/46
(month) (day) (year)Cemetery or crematory Alpine Cem.Location St. Ashby, W. Va.18. Funeral director Louis Steiner, Inc.Address 117 Frederick Street Cumberland19. July 20 1946 Joseph B. [unclear]
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1946 at 1:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him Dead July 17 1946

Immediate cause of death

Crushed Skull & fracturedcervical vertebrae Immediately

DUE TO

DUE TO

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7-17-46Where did injury occur? Cumberland Allegany Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) in street inMeans of injury Truck ran over head front 318 Cecelia St.23. SIGNATURE H.V. Deming M.D. H.V. Deming
M. D. or otherAddress 125 Bedford St. Date signed 7/17/46Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 23 1946

BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

06606

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1454

1. PLACE OF DEATH:

County... Allegany
City or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany County Infirmary
How long in hospital or institution? 8 Months 23 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... Maryland County... Allegany
City or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No... Hammersmith's Hotel
(If rural, give LOCATION)
2.(a) If veteran, name War...

3. (a) FULL NAME

Charles Burgess

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Unknown

6.(b) Name of husband or wife

6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1877 Unknown

8. AGE: Years 69? Months Days If less than one day hrs. min.

9. Birthplace Unknown
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Odd jobs.

12. Name

13. Birthplace Unknown

14. Maiden name

15. Birthplace

16. Informant Allegany Co. Infirmary

Address Cumberland, Md.

17. Bureau Date thereof Aug. 1, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Patrick's Cem

Location Cumberland, Md

18. Funeral director William H. Kight

Address Cumberland, Md.

19. July 31, 1946 J.P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30, 1946, at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 6 45 to 7. 30. 46
and that I last saw him live on 7. 29. 46

Immediate cause of death Generalized Arterio Sclerosis
Due to Infirmitis of age.
Other conditions

(Include pregnancy within 3 months of death)
Major findings of operations None
Date of op. none

Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE F.F. Williams
Address Cumberland Date signed 7. 30. 46

MARGIN RESERVED FOR BINDING

VS A15 - 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 2 1946
BUREAU V S.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County.....ALLEGANY
City or town.....CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....4 H Hours
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution?.....4 HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State.....PENNA. County.....SOMERSET
City or town.....MEYERSDALE
(If outside city or town limits, write RURAL and give nearest town)
Street No.....332 MEYERS AVE.
(If rural, give LOCATION)
2.(a) If veteran, name War.....

3.(a) FULL NAME

CHARLES CANONICO

3.(b) Social Security Number

None

4. Sex.....MALE
5. Color or race.....WHITE
6.(a) Single, married, widowed, or divorced.....MARRIED

6.(b) Name of husband or wife.....LUCY PERRINO

6.(c) If alive, give age.....57 years

7. Birth date of deceased (mo., day, yr.).....DECEMBER 6 1877

8. AGE: Years.....68 Months.....7 Days.....12 If less than one day.....hrs.min.

9. Birthplace.....ITALY
(Town, county, and state)

10. Usual occupation.....RETIRED

11. Industry or business.....Coal Miner

12. Name.....CARL CANONICO

13. Birthplace.....ITALY

14. Maiden name.....CAROLINE ?

15. Birthplace.....ITALY

16. Informant.....MEMORIAL HOSPITAL

Address.....CUMBERLAND, MD.

17. Burial Date thereof.....7/10/46
(Burial, cremation, or removal. Which?).....(month) (day) (year)

Cemetery or crematory.....Catholic Cemetery

Location.....Meyersdale, Pa.

18. Funeral director.....Timothy Kohnhaus

Address.....Meyersdale, Pa.

19. July 9, 46. J. P. Franklin, M.D.
(Date rec'd by registrar).....Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....JULY 8, 1946, at 3:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

JULY 8, 1946, to JULY 8, 1946,

and that I last saw him alive on JULY 8, 1946.

Immediate cause of death.....Acute Pancreatitis

Due to.....

Due to.....

Other conditions.....Diabetes

(Include pregnancy within 3 months of death)

Major findings of operations.....no

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....(City or town).....(County).....(State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....A. H. Hawken

Address.....Cumberland Date signed.....7-9-46

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 16 1946

BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 548

CERTIFICATE OF DEATH

Reg. Dist. No.

07465

4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11. Years
Hospital, institution, or street address where death occurred:
14. Massachusetts Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 14. Massachusetts Ave
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Paul George Cessna

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
6. (b) Name of husband or wife
B. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 13, 1935
8. AGE: Years 11 Months 2 Days 29 If less than one day hrs. min.

9. Birthplace Cumberland, Allegany Co., Maryland
(Town, county, and state)

10. Usual occupation School

11. Industry or business "

FATHER 12. Name Paul L. Cessna
13. Birthplace Barrelsville, Md.
MOTHER 14. Maiden name Della Jolly
15. Birthplace Cumberland, Md.

16. Informant Paul. L. Cessna
Address 14. Massachusetts Ave, Cumberland, Md.

17. Burial Date thereof 7/14/46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Trinity Luthern Cemetery
Location Cumberland, Md.

18. Funeral director William H. Kight
Address Cumberland, Md.

19. July 14, 1946 Date rec'd by registrar J. P. Franklin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12, 1946 at 7-20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1946 to July 12, 1946
and that I last saw him alive on July 12, 1946

Immediate cause of death

DURATION

Brain Tumor 10 mon.
Due to Malignant. Cerebr.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Brain Tumor
Date of op. Jan. 1946

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clayton J. Jurek M. D. or other
Address Cumberland Date signed July 15, 1946

MARGIN RESERVED FOR BINDING

I

VS-A15 9-45-11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 23 1946
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 946

06608

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumtland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 46 yrs.

Hospital, institution, or street address where death occurred:

308 Harrison St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumtland
(If outside city or town limits, write RURAL and give nearest town)Street No. 308 Harrison St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

James A Close — JAMES ASKEY CLOSE

3. (b) Social Security Number

717-10-65774. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Sarah A. Murray

7. Birth date of deceased (mo., day, yr.)

July 5 1896

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

491127

hrs.

min.

9. Birthplace Midland Ind.
(Town, county, and state)

10. Usual occupation

Printer

11. Industry or business

Cumtland Evening Times

12. Name

William Close

13. Birthplace

Ind.

14. Maiden name

Elizabeth Askey

15. Birthplace

Ind.

16. Informant

Mrs Sarah M. Close

Address

Cumtland Ind.17. Burial
(Burial, cremation, or removal. Which?)Date thereof July 5 46
(month) (day) (year)

Cemetery or crematory

Hillcrest bch.

Location

Cumtland Ind

18. Funeral director

Louis Stein

Address

Cumtland19. July 5 19 46
(Date rec'd by registrar)J. P. Franklin M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2-1946 19....., at 3.20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him Dead July 2 19 46

Immediate cause of death

Coronary occlusion

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. V. Deming M.D.

M. D. or other

Address

CumtlandDate signed 7-3-46

Deputy Medical Examiner - Allegany Co.

RECEIVED

JUL 6 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (572)

CERTIFICATE OF DEATH

Reg. Dist. No. 9

06609

1. PLACE OF DEATH:
 County Allegany
 City or town Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? _____
 Hospital, institution, or street address where death occurred:
Miners Hospital
 How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Ind County Allegany
 City or town Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 92 Beall St. Ext.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME
Baby Boy Cole

3. (b) Social Security Number
✓

4. Sex Male 5. Color or race C 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife _____
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) July 18, 1946
 8. AGE: Years _____ Months 4 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Frostburg, Allegany, Ind.
 (Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

FATHER 12. Name Gerald Cole
 13. Birthplace Frostburg, Ind.

MOTHER 14. Maiden name Anna Harper
 15. Birthplace Frostburg, Ind.

16. Informant Mr. Gerald Cole
 Address 92 Beall St. Ext. Frostburg

17. Burial ✓ Date thereof 7-21-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Allegany
 Location Frostburg, Ind.

18. Funeral director Mr. Gerald Cole
 Address 92 Beall St. Ext. Frostburg, Ind.

19. 7-21 46 Mrs. Nancy N. Roe
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 19 46 at 5:10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18 19 46 to July 21 19 46
 and that I last saw him alive on July 21 19 46

Immediate cause of death _____

Potent foramen ovale
 Due to _____

Due to _____

Other conditions Premature & mac.

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (Country) _____ (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE J.C. Diehl, M.D.
 M. D. or other _____
 Address Frostburg, Ind. Date signed 7/21/46

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

JUL 23 1946

BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-2)

C6510

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany
 City or town Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 year 4 mos.
 Hospital, institution, or street address where death occurred:
Summit Street Extended
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)
 State Maryland County Allegany
 City or town Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Summit Street Extended
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Francis Cominsky

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife William Cominsky
 8. (c) If alive, give age 61 1/2 years
 7. Birth date of deceased (mo., day, yr.) — 1876
 8. AGE: Years 70 Months — Days — If less than one day hrs. min.

9. Birthplace Swalkus, Lithuania
 (Town, county, and state)

10. Usual occupation Horse work

11. Industry or business Own home

12. Name Unknown

13. Birthplace Lithuania

14. Maiden name Repos

15. Birthplace Lithuania

16. Informant Mr. Stanley Duckworth

Address Frostburg, Maryland

17. (Burial, cremation, or removal. Which?) Burial Date thereof July 15, 1946
 (month) (day) (year)

Cemetery or crematory St. Michael's Cemetery

Location Frostburg, Md.

18. Funeral director W. Eichhorn

Address Conowingo, Md.

19. 7-13 19 46 Mr. Dacey Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12, 1946 at 12:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1945 to July 12, 1946

and that I last saw him/her alive on July 10, 1946

Immediate cause of death C-V-Renal disease DURATION 2 yrs.

Due to

Due to

Other conditions Cerebral Apoplexy 2 yrs.

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE W. D. Gattens MD M. D. or other

Address Frostburg, Md. Date signed 7/13/46

RECEIVED

JUL 16 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 56 yrs
 Hospital, institution, or street address where death occurred
209 Cecelia St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 209 Cecelia St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war 1st World War

3. (a) FULL NAME

Louis Victor Cornell

3. (b) Social Security Number

705-05-8080

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) November 8 1889
 8. AGE: Years 58 Months 8 Days 6 If less than one day _____ hrs. _____ min.

9. Birthplace Cumberland Ind
 (Town, county, and state)
 10. Usual occupation Clark
 11. Industry or business Train master B & O Ry
 12. Name Thomas Cornell
 13. Birthplace Ireland
 14. Maiden name Mary Murray
 15. Birthplace Penna.

MOTHER FATHER
 16. Informant Wm Gannall
 Address Cumberland
 17. Burial, cremation, or removal (which?) Burial Date thereof July 17 46
 (month) (day) (year)
 Cemetery or crematory St. Patrick's Cem
 Location Cumberland
 18. Funeral director Archie Stein Inc
 Address Cumberland
 19. Date rec'd by registrar July 16 46 Registrar M. L. G. Freepia

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1946 at 5 A M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-6-45 to 7-12-46
 and that I last saw him alive on 7-12-46

Immediate cause of death Coronary occlusion DURATION Sudden
 Due to
 Due to
 Other conditions Myocarditis 1 yr.
Cardiac hypertrophy 1 yr.
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE O. O. Zimmerman M. D. or other
 Address Cumberland, Md. Date signed 7-15-46

RECEIVED
JUL 22 1946
BUREAU V.B.

2411 N. Charles St., Baltimore (B-6)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 55 yearsHospital, institution, or street address where death occurred:
Memorial HospitalHow long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 424 Baltimore Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Pauline Cookley

3. (b) Social Security Number

None4. Sex F5. Color or race W

6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of husband or wife James W. Cookley

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 1, 1873

8. AGE: Years Months Days If less than one day

72 11 28 hrs. min.9. Birthplace Bedford, Pa.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own home12. Name John Steinboach13. Birthplace Germany14. Maiden name Lena Everbach15. Birthplace Germany16. Informant Mrs. Naomi S. HallAddress Cumberland, Md17. Burial Date thereof July 31, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Cumberland, Md.18. Funeral director John J. HofusAddress Cumberland, Md.19. July 31, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29, 1946, at 7:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2, 1946, to July 29, 1946, and that I last saw him alive on July 29, 1946.Immediate cause of death Angina pectoris

DURATION

6 yearsDue to Organic heart disease 29Due to Chronic nephritis 29

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thomson H. Hall M. D. or otherAddress Cumberland, Md. Date signed July 31, 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

IN THE CITY OF NEW YORK

1. Name of deceased: *John Doe*
2. Sex: *Male*
3. Age: *45*
4. Date of death: *August 1, 1946*
5. Place of death: *Home*
6. Cause of death: *Heart Disease*
7. Signature of physician: *[Signature]*
8. Signature of registrar: *[Signature]*

RECEIVED
AUG 2 1946
BUREAU V 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 466

CERTIFICATE OF DEATH

Reg. Diat. No. 00613/0

1. PLACE OF DEATH:

County AlleghenyCity or town Barrellville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 yrs.Hospital, institution, or street address where death occurred: Mt Savage Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County AlleghenyCity or town Barrellville
(If outside city or town limits, write RURAL and give nearest town)Street No. Mt Savage Rd.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Hubert Elrick

3. (b) Social Security Number

4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Emmie Wilhelton6. (c) If alive, give age 73 years7. Birth date of deceased (mo., day, yr.) April 12 18838. AGE: Years 63 Months 3 Days 7 If less than one day

hrs. min.

9. Birthplace Kellersburg Pa.
(Town, county, and state)10. Usual occupation Factory11. Industry or business General12. Name James Elrick13. Birthplace Cumberland Ind.14. Maiden name Ellen Brunham15. Birthplace Pa.16. Informant Mrs Annie H. ElrickAddress Barrellville Ind.17. Burial Date thereof July 17 46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Lutheran Cem.Location Kellersburg Pa.18. Funeral director Louis Stein IncAddress Cumberland19. July 16 1946 Vernice McDermott
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1946 at 5:25 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 12 46 to July 14 46and that I last saw him alive on July 14 46Immediate cause of death Lung Carcinoma

DURATION

Unknown

Due to

Due to

Other conditions Chronic Bronchial asthma years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William E. Moseley M.D.

M.D. or other

Address Mt Savage Ind Date signed 7/16-1946

RECEIVED

JUL 23 1946

BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore ¹¹⁷⁻⁶

CERTIFICATE OF DEATH

06614

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumtberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

27 S. Liberty St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumtberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 27 S. Liberty St.
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

James R Engle

3. (b) Social Security Number

715-17-23314. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Margaret E Diehl

7. Birth date of

deceased (mo., day, yr.)

Oct 19 1884

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

6192

hrs.

min.

9. Birthplace

Cumtberland W. Va.

(Town, county, and state)

10. Usual occupation

Leather worker

11. Industry or business

Tannery

FATHER

12. Name

William Engle

13. Birthplace

W. Va.

14. Maiden name

Rachel Fishell

15. Birthplace

W. Va.

16. Informant

Mrs Margaret E Engle

Address

Cumtberland

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

July 25 '46

Cemetery or crematory

St Peter & Paul Cumtberland

Location

Cumtberland

18. Funeral director

Louis Steyn Inc

Address

Cumtberland

19.

(Date rec'd by registrar)

July 24, 1946 J P Franklin, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 21

19

46 at 7:15 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him alive on

19

Immediate cause of death

Acute Indigestion

DURATION

Due to

Chronic duodenal ulcer2 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

Chronic duodenal ulcer

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Deputy Medical Examiner Allegany Co.

23. SIGNATURE

H. V. Deming M.D.

M. D. or other

Address

125 Bedford St.Date signed 7-22-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 30 1946
BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1154

06615

CERTIFICATE OF DEATH

★ Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. R.D.#4
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Charles Patrick Fairall

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

8. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.) July 8, 1939

8. AGE:

Years

Months

Days

It less than one day

61123

hrs.

min.

9. Birthplace

Cumberland, Md.

(Town, county, and state)

10. Usual occupation

Student

11. Industry or business

FATHER
MOTHER12. Name Patrick F. Fairall13. Birthplace Cumberland, Md.14. Maiden name Lillian Bramble15. Birthplace Cumberland, Md.16. Informant Mr. Patrick FairallAddress R.D.#4 Cumberland, Md.17. Burial
(Burial, cremation, or removal. Which?)Date thereof July 4, 1946
(month) (day) (year)Cemetery or crematory Mt. Herman Cem.Location Near Cumberland, Md.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.19. July 2, 1946
(Date rec'd by registrar)Registrar J. P. Franklin, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1, 1946 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 15 - 1946 to July 1, 1946
and that I last saw him alive on July 1, 1946

Immediate cause of death

uremia

DURATION

4 days

Due to

Chronic nephritis4 days

Due to

raw throat

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William M.D.

M. D. or other

Address

Long M.D.Date signed 7-2-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 9 1946

BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 9

06616

1. PLACE OF DEATH:

County AlleganyCity or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? All his life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Thomas Farrady4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Louisa Beaman

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 24 - 18808. AGE: Years 66 Months 0 Days 17 If less than one day _____ hrs. _____ min.9. Birthplace Frostburg, Allegany, Md.
(Town, county, and state)10. Usual occupation Retired11. Industry or business Coal Miner12. Name John Farrady13. Birthplace Frostburg, Md.14. Maiden name Margaret Beaman15. Birthplace Allegany16. Informant Mrs. Grace DeussmoreAddress 1215 Benson St. Bath, Md.17. Burial Date thereof 7-12-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory AlleganyLocation Frostburg18. Funeral director Joseph WagnerAddress Frostburg, Md.19. 7-12 19 46 Mrs. Xaney N. Rose
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County AlleganyCity or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)Street No. 152 Barbary St.
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 19 46 at 17:00 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4 19 46 to July 10 19 46and that I last saw him alive on July 8 19 46

Immediate cause of death _____

C-V-Renal disease

Due to _____

Due to _____

Other conditions Angine N. lig

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. E. Statterup M.D. M. D. or other _____Address Frostburg, Md. Date signed 7/11/46

RECEIVED
JUL 15 1946
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94E

CERTIFICATE OF DEATH

Reg. Dist. No. 06617 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County GarrettCity or town Accident Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. Rural

(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

George Leroy Felix

3. (b) Social Security Number

232-09-4062

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Married8. (b) Name of husband or wife Florence Wilson Felix5. (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.)

Aug 7 1901

8. AGE:

Years

Months

Days

If less than one day

44114

hrs.

min.

9. Birthplace Williamsport, Pa.

(Town, county, and state)

10. Usual occupation Pipe fitter11. Industry or business Dupont Chemical Co12. Name John Felix13. Birthplace Pa14. Maiden name Isabelle Krebs15. Birthplace Pa.16. Informant Mrs. Florence FelixAddress Accident Md.17. Burial
(Burial, cremation, or removal. Which?)Date thereof July 13, 1946
(month) (day) (year)Cemetery or crematory Freezeville CemLocation Freezeville, W. Va.18. Funeral director John J. HagerAddress Cumberland Md.19. July 11, 46
(Date rec'd by registrar)J. P. Franklin Md.
Registrar

MEDICAL CERTIFICATION about

20. DATE OF DEATH July 11 19 46, at 7 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 46 to 19 46and that I last saw him dead July 11 19 46

Immediate cause of death

Angina Pectoris

DURATION

about 1 year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or otherAddress 125 Bedford St Date signed 7-11-46
Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 16 1946

BUREAU V.B.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157

06618

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Near Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rural # 1. Latale
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Infant Boy Fisher
4. Sex MALE 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
B. (b) Name of husband or wife
7. Birth date of deceased (mo., day, yr.) July 21, 1946 6. (c) If alive, give age years
8. AGE: Years Months Days If less than one day 5 hrs. min.

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 19 46 at 9:30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-21-46 19 46 to 7-31-46 19 46
and that I last saw him alive on 7-21-46 19 46
Immediate cause of death
Premature Birth
Due to 6/24/46
Due to Obstet. Pregnancy
Other conditions
(Include pregnancy within 3 months of death)

DURATION

9. Birthplace Cumberland, Allegany Co., Maryland
(Town, county, and state)
10. Usual occupation
11. Industry or business
12. Name James L. Fisher
13. Birthplace Wytheville, Virginia
14. Maiden name Josephene Lange
15. Birthplace Baltimore, Md.
16. Informant James L. Fisher
Address Rt. 1, Latale, Cumberland, Md.
17. Burial Date thereof 7/25/46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Zion Memorial Cemetery
Location Cumberland, Md.
18. Funeral director William H. Kight
Address Cumberland, Md.
19. July 24, 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE J. P. Franklin, M.D. M. D. of other
Address Cumberland, Md. Date signed 7-22-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 30 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06619

Reg. Dist. No.

4

1. PLACE OF DEATH:

County AlleganyCity or town Cumtberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 82 yrsHospital, institution, or street address where death occurred 705 May St

How long in hospital or institution

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumtberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 705 May St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Richard Lenwood Fisher

3. (b) Social Security Number

214-05-97374. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Augusta Fisher

8. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Oct 7 1887

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Cumtberland Ind.
(Town, county, and state)10. Usual occupation Service man11. Industry or business K. S. Tire Co.12. Name John Fisher13. Birthplace Ind.14. Maiden name Mary Reed15. Birthplace Ind.16. Informant William E. FisherAddress Cumtberland17. Burial Burial Date thereof July 9, 46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Unity Lutheran Cem.Location Cumtberland18. Funeral director Louis Stein, IncAddress Cumtberland19. July 8, 46 J. P. Franklin, M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 19 46 at 8:30 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4 19 46 to July 5 19 46and that I last saw him alive on July 5 19 46Immediate cause of death Chronic myocarditisDue to Bronchial asthma

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE P. K. Treviski, M.D.Address Cumtberland, Md Date signed July 6-46

M. D. or other

Address _____ Date signed _____

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 16 1946

BUREAU V.E.

Within corporate limits

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

CERTIFICATE OF DEATH

Reg. Dist. No. 06620 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 years
Hospital, institution, or street address where death occurred:
312 Franklin St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 312 Franklin St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Pearl Forster
3. (b) Social Security Number None

4. Sex F
5. Color or race W
6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Gottlieb Forster

7. Birth date of deceased (mo., day, yr.) April 5, 1897
6. (c) If alive, give age 52 years

8. AGE: Years 49 Months 3 Days 13
If less than one day
..... hrs. min.

9. Birthplace Lanesboro, Allegany, Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

12. Name James D. Peebles

13. Birthplace Lanesboro, Md.

14. Maiden name Luey Corfield

15. Birthplace Moscow, Md.

16. Informant Gottlieb Forster

Address Cumberland, Md.

17. Burial
(Burial, cremation, or removal. Which?) Date thereof July 21, 1946
(month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hofer

Address Cumberland, Md.

19. July 20, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18, 1946 at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4, 1946 to July 18, 1946
and that I last saw him/her alive on July 18, 1946

Immediate cause of death Cerebral Hemorrhage

Due to arteriosclerosis

Due to hypertension

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. P. Franklin

Address 36 Howard St. Cumberland Md M. D. or other

Date signed 7/19/46

RECEIVED

JUL 23 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 180

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny

City or town Corriganville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 107 days

Hospital, institution, or street address where death occurred:

Allegheny Hospital

How long in hospital or institution? 107 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegheny

City or town Corriganville
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2. (a) If veteran, name war. _____

3. (a) FULL NAME

Clark Galen Fridley

3. (b) Social Security Number

None

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife _____

8. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) March 28, 1942

8. AGE: Years Months Days If less than one day

4 3 21 hrs. min.

9. Birthplace Ridgely, Mineral, W. Va.
(Town, county, and state)

10. Usual occupation child

11. Industry or business _____

FATHER 12. Name Conrad Fridley

13. Birthplace Parsons, W. Va.

MOTHER 14. Maiden name Nellie Justice

15. Birthplace Parsons, W. Va.

16. Informant Conrad Fridley

Address Corriganville, Md.

17. Burial Date thereof July 22, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Ft. Ashby Cemetery

Location Ft. Ashby, W. Va.

18. Funeral director John J. Hefner

Address Chamberland, Md.

19. July 22, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19, 1946 at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 26, 1946 to July 19, 1946 and that I last saw him alive on July 19, 1946

Immediate cause of death Alphacrisis

Due to _____

Due to _____

Other conditions Alphacrisis

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Elizabeth H. Brown, M.D.

Address Cray, Md. Date signed 7/21/46

06621

RECEIVED
JUL 30 1945
BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 164-6

06622

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 yrs.

Hospital, institution, or street address where death occurred:

W. Bond Bridge - Brooker TunnelHow long in hospital or institution: —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 221 Humbird
(If rural, give LOCATION)2. (a) If veteran, name war: —

3. (a) FULL NAME

Antonio Geofre(Joe fra) (Joffre)

3. (b) Social Security Number

?4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Divorced6. (b) Name of husband or wife: Unknown

7. Birth date of

deceased (mo., day, yr.)

Oct 1 18796. (c) If alive, give age: — years

8. AGE:

Years

Months

Days

If less than one day

6698

hrs.

min.

9. Birthplace:

Mass., Italy
(Town, county, and state)

10. Usual occupation:

Gardener

11. Industry or business

MOTHER FATHER

12. Name:

Walter Louis Santa Giffre

13. Birthplace

Italy

14. Maiden name:

Terese Sgro

15. Birthplace

Italy

16. Informant:

H. V. Deming, M.D.

Address

Cumberland

17. Burial (Burial, cremation, or removal. Which?)

Date thereof July 12 46
(month) (day) (year)

Cemetery or crematory

St. Marys Cemetery

Location

Cumberland

18. Funeral director:

Louis Stein, Inc.

Address

Cumberland19. Date rec'd by registrar: July 12 46J. P. Frankel, M.D.
Registrar

MEDICAL CERTIFICATION about

20. DATE OF DEATH July 9 19 46, at 11:30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 — to 19 —and that I last saw him Dead July 9 19 46

Immediate cause of death:

Suicide by drowning

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op. 7-9-46Autopsy results: water in lungs

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: suicide Date of 7-9-46Where did injury occur? Cumberland Allegany Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Potomac River

Means of Injury

Injured at work?

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or otherAddress CUMBERLANDDate signed 7-10-46

MARGIN RESERVED FOR BINDING

VS A15

9.45.13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 16 1946

BUREAU V.E.

Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06623

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
Near Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 years
Hospital, institution, or street address where death occurred

Park Heights, R. F. D. #1

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Allegheny
City Near Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Park Heights, R. F. D. #1
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Edward N. Glynn

3.(b) Social Security Number

127-09-3697

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Ethel D. Glynn

6.(c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) June 26, 1905

8. AGE: Years 41 Months 1 Days 0 If less than one day
..... hrs. min.

9. Birthplace Seibert, Allegheny, Md
(Town, county, and state)

10. Usual occupation Insurance agent

11. Industry or business Metropolitan Life Ins. Co.

12. Name Joseph P. Glynn

13. Birthplace Lake Detroit, Minn.

14. Maiden name Sophia Rephann

15. Birthplace Seibert, Md.

16. Informant Mrs. Ethel D. Glynn

Address Cumberland, Md

17. Burial Date thereof July 29, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Riverside Cemetery

Location Oneonta, New York

18. Funeral director John J. Haffer

Address Cumberland, Md.

19. July 28, 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1946 at 11.15 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....

and that I last saw him alive on July 26 1946

Immediate cause of death

Acute cardiac dilatation At once

Due to Acute indigestion and one

vomiting hour

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.

Address Cumberland Md Date signed 7.26/46

..... M. D. or other

.....

.....

.....

MARGIN RESERVED FOR BINDING

9-45-19

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 2 1946

BUREAU V.E.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Allagany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Days

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Garrett

City or town Swanton
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

Mr. Charles Green

3.(b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

8.(b) Name of husband or wife Florence Green

8.(c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) March 31, 1891

8. AGE: Years 55 Months 3 Days 18 If less than one day _____ hrs. _____ min.

8. Birthplace Pennsylvania
(Town, county, and state)

10. Usual occupation Postal Clerk

11. Industry or business

12. Name Green Joseph

13. Birthplace Unknown

14. Maiden name Laura Edgar

15. Birthplace Unknown

16. Informant Memorial Hospital

Address Cumberland, Maryland

17. (Burial, cremation, or removal. Which?) Burial Date thereon July 31, 1946
(month) (day) (year)

Cemetery or crematory Swanton, Md.

Location Garrett Co., Md.

18. Funeral director Herbert C. Leighton

Address Cabland, Md.

19. July 20, 1946 J. P. Franklin, M.D.
Date rec'd by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18, 1946 at 7:15 a

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-6- 1946 to 7-18- 1946

and that I last saw him alive on 7-17- 1946

Immediate cause of death massive pulmonary emboli

R femoral thrombophlebitis

Due to Benign hypertrophy of prostate

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Autopsy results as above stated

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Howard G. Gahan, M.D.

Address Cumberland, Md. Date signed 7-19-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 23 1946

BUREAU V.B.

Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 922

CERTIFICATE OF DEATH

★ 06625 4
Reg. Dist. No.

1. PLACE OF DEATH:

County Alleghany
City or town Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs
Hospital, institution, or street address where death occurred:
Oldtown Rd. Route # 4
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Alleghany
City or town Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route # 4 Oldtown Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Anna E Hamilton

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced widowed
6.(b) Name of husband or wife George T Hamilton
6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) Sept 17 1884
8. AGE: Years 61 Months 9 Days 15 If less than one day _____ hrs. _____ min.

9. Birthplace McIntoshville Va.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business at Home

12. Name Jas. Polk Shipplet

13. Birthplace Va.

14. Maiden name Martha In Williams

15. Birthplace Va.

16. Informant Chas Woods

Address Rt #4 Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 5 46
(month) (day) (year)

Cemetery or crematory St. Ann's Church

Location Oldtown Rd.

18. Funeral director Louis Stein Inc

Address Cumberland

19. July 5 19 46 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2, 1946 at 1:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1946 to July 2, 1946 and that I last saw him alive on July 1, 1946

Immediate cause of death Chronic Myocarditis DURATION 2 yrs

Due to Coronary Thrombosis 12 hrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John E. Lunn

Address Cumberland Date signed July 2, 1946
M. D. or other

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

James E. McLaughlin

RECEIVED
JUL 6 1946
BUREAU V.S.

RECEIVED AS A BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

06627

4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 35 Years
 Hospital, institution, or street address where death occurred:
60 Marion St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 60 Marion St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3.(a) FULL NAME

George Henry Hardin

3.(b) Social Security Number

220-07-6606

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Mary Frances Hardin
 6.(c) If alive, give age 61 years
 7. Birth date of deceased (mo., day, yr.) August 16 1876
 8. AGE: Years 69 Months 11 Days 0 If less than one day
 hrs. min.

9. Birthplace Dunbar, Pa.
 (Town, county, and state)
 10. Usual occupation Carpenter
 11. Industry or business Building Houses
 12. Name Jacob Hardin
 13. Birthplace Dunbar, Pa.
 14. Maiden name Nancy Bowman
 15. Birthplace Kingwood, W. Va.
 16. Informant Mrs. George H. Hardin
 Address 60 Marion St, Cumberland, Md.

17. Burial Date thereof 7/19/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Zion Memorial Cemetery
Cumberland, Md.
 Location

18. Funeral director William H. Kight
 Address Cumberland, Md.

19. July 19 46 Registrar Joseph C. Brantley
 Date rec'd by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 19 46, at 5 A.M. about
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19 46 at 5 A.M. and that I last saw him im dead July 16 19 46

Immediate cause of death Coronary occlusion DURATION immediate

Due to Arteriosclerosis several years

Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE H.V. Deming M.D. H. V. Deming M.D.
 M. D. or other
 Address Date signed

MARGIN RESERVED FOR BINDING

VS A15

9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 23 1946

BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06628

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 Hours 20 Minutes

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 4 hours 20 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)Street No. 7134 Bradley Boulevard
(If rural, give LOCATION)2. (a) If veteran, name war Second World War

3. (a) FULL NAME

James Hoard

3. (b) Social Security Number

579-01-6956

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhiteMarried6. (b) Name of husband or wife Sonya Hoard6. (c) If alive, give age 26 years7. Birth date of deceased (mo., day, yr.) June 21, 19118. AGE: Years Months Days If less than one day
35 0 22 hrs. min.9. Birthplace Arlington County, Virginia
(Town, county, and state)10. Usual occupation Office Mgr.11. Industry or business Coal & Fuel Oil12. Name James Willet13. Birthplace Washington, D. C.14. Maiden name Elsie Newlon15. Birthplace Washington, D. C.18. Informant Memorial HospitalAddress Cumberland, Maryland17. Burial Date thereof 7/16/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington CemeteryLocation Arlington, Va.18. Funeral director William H. KightAddress Cumberland, Md.19. July 15 46 J. R. Franklin
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1946 at 7:35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 12 1946 to July 13 1946and that I last saw him alive on July 13 - 8:16Immediate cause of death collapse following DURATIONcrushed chestautomobile accident

Due to

Due to

Other conditions long fracture of left armfracture into

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7/12/46Where did injury occur? Road (City or town) (County) (State)Injured at home, farm, industry, public place (where?) RoadMeans of injury Auto collision Injured at work?23. SIGNATURE J. R. Franklin M. D. or otherAddress Cumberland, Md. Date signed 7/18/46

MARGIN RESERVED FOR BINDING

VS A15 9.45.15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 23 1946
BUREAU V F

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 44

CERTIFICATE OF DEATH

06629

Reg. Dist. No. 9

1. PLACE OF DEATH:

County alleganyCity or town Smithsburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Rose Hughes

7. Birth date of deceased (mo., day, yr.)

April 25 - 1862

8. AGE:

Years

Months

Days

If less than one day

74

2

7

hrs.

min.

9. Birthplace

md. Savage - alleg - md.
(Town, county, and state)

10. Usual occupation

watchman

11. Industry or business

Filtration plant

MOTHER FATHER

12. Name

Thos. Hughes

13. Birthplace

England

14. Maiden name

unknown

15. Birthplace

16. Informant

Wm. Hughes

Address

Smithsburg, md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

July 7, 1946
(month) (day) (year)

Cemetery or crematory

allegany

Location

Smithsburg

18. Funeral director

Address

Smithsburg, md.

19.

7-16
(Date rec'd by registrar)

19.

46 Mrs. Nancy A. Roe
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 3

1946, at 6:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 30

1946

to July 3

1946

and that I last saw him alive on

July 3

1946

Immediate cause of death

Hodgkins Disease

DURATION

Seven months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

RECEIVED
JUL 9 1946
BUREAU V. M.

File as Death

(159)

BIRTH AND DEATHMARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OFReg. Dist. No. 6

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County Allegheny
City or town Westernport
(If outside city or town limits, write RURAL and give nearest town)
Street address, hospital, or institution:
Kolberg Hill
Length of mother's stay in County 30 years
(How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Maryland
County Allegheny
City or town Westernport
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route 1, Box 2 (Kolberg Hill)
(If RURAL give LOCATION)

3. Name of child

None

5. Sex

Male

6. Twin or triplet

No

4. Date of birth

July 19, 1946 Hour 12:40 A.M.

7. No. of weeks pregnancy

20 weeks

FATHER OF CHILD

8. Full name Francis John Humes
9. Color White 10. Age at time of this birth 30 yrs.
11. Usual occupation Spinner in Silk Mill

MOTHER OF CHILD

12. Full maiden name Kathleen Elizabeth McKenzie
13. Color White 14. Age at time of this birth 30 yrs.
15. Usual occupation Housewife16. Other children born to mother (not including present child): (a) How many children of this mother are now living? Two
(b) How many other children were born alive but are now dead? None (c) How many other children were born dead? None17. Did child die before labor? No During labor? No
18. Pregnancy, complications of Premature Rupture of Amniotic Sac19. Labor: (a) Complications of None
(b) Induced? No20. (a) Was there an operation for delivery? Yes
(b) State all operations, if any Right ovarian cyst removed May 20, 1946
(c) Did child die before operation? No
During operation? No

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes Premature Delivery
(b) Maternal causes Premature Rupture of Amniotic Sac22. I certify to the birth of this child who was born dead on the date and hour above stated.Signature Paul R. Wilson M.D.
(Specify if M.D., midwife, or other)Address Piedmont, W. Va.23. (a) Burial (b) Date thereof July 19, 1946
(Burial, cremation or removal) (month) (day) (year)
(c) Cemetery or crematory Private Cemetery24. (a) Funeral director Francis Humes
(b) Address Westernport, Md.25. (a) July 19, 1946 (b) Paul R. Wilson M.D.
(Date rec'd by registrar) (Registrar)26. (To be filled out if no physician was present at delivery.)
The above certificate has been examined by me.

Health Officer, per

* See Instruction C on stub.

CHILD LIVED 3 Hours 20 Minutes

V. S. A10

RECEIVED

JUL 22 1946

BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH:

County mt. AlleganyCity or town mt. Savage
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County alleganyCity or town mt. Savage
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Jethro M. Jeffries

3. (b) Social Security Number

712-14-15634. Sex m 5. Color or race w 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Stella C. Jeffries7. Birth date of deceased (mo., day, yr.) Oct 29-1884 6. (c) If alive, give age 59 years8. AGE: Years 61 Months 8 Days 21 If less than one day hrs. min.9. Birthplace Frostburg-Alleg-Md.
(Town, county, and state)10. Usual occupation retired11. Industry or business rail road12. Name Jethro Jeffries13. Birthplace England14. Maiden name Margaret Williamson15. Birthplace Frostburg, Md.16. Informant Mrs. Stella C. JeffriesAddress mt. Savage, Md.17. Burial (Burial, cremation, or removal. Which?) Date thereof July 22-1946
(month) (day) (year)Cemetery or crematory alleganyLocation Frostburg, Md.18. Funeral director J. J. G. G. G.Address Frostburg, Md.19. July 21 19 46 Veronica McDermott
(date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 19 46 at 4:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 46, to July 20 19 46.
and that I last saw him alive on July 19 19 46.Immediate cause of death Pneumonia of Brain DURATION 6 hrs

Due to

Due to

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. W. G. G. G. M. D. or otherAddress Cum gratia Date signed July 20 19 46

RECEIVED
JUL 23 1946
BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

C6631

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County AlleganyCity or town Luke

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 yrs.

Hospital, institution, or office address where death occurred:

411 Pratt

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Luke

(If outside city or town limits, write RURAL and give nearest town)

Street No. 411 Pratt.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Thomas Aloysius Kelley, Sr.

3.(b) Social Security Number

212-12-8106

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Lula Kelley6.(c) If alive, give age 68 years7. Birth date of deceased (mo., day, yr.) April 15, 1864

8. AGE: Years Months Days If less than one day

8231

hrs. min.

9. Birthplace Piedmont-Mineral-W. Va.

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Paper-Mill

12. Name

Thomas Kelley

13. Birthplace

Ireland

14. Maiden name

Mary Twohill

15. Birthplace

Ireland

16. Informant

Thomas A. Kelley, Jr.

Address

Piedmont, W.Va.17. Burial Date thereof July 18, 46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Philos Cem.Location Westernport, Md.18. Funeral director Ellsworth S. BoalAddress Westernport, Md.19. July 17, 46 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 19 46 at 6A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 18 19 43 to July 16 19 46and that I last saw h. alive on July 15 19 46

Immediate cause of death

Carcinoma of Bladder

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. Berry M. D. or otherAddress Piedmont W.Va. Date signed 7-17-46

RECEIVED

JUL 18 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 56-1

CERTIFICATE OF DEATH

07463

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany
 City or town Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 days
 Hospital, institution, or street address where death occurred:
Spencer's Hospital
 How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)

State MD County Allegany
 City or town Frostburg, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 62 N. Water
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Allen Clinton Kennell

3. (b) Social Security Number

213-10-9121

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Bulah Hansen
 7. Birth date of deceased (mo., day, yr.) Sept. 26 - 1903
 8. AGE: Years 41 Months 8 Days 16 If less than one day
hrs. min.

9. Birthplace Ellerslie, Md.
 (Town, county, and state)

10. Usual occupation Press mechanic

11. Industry or business Bruckyard

12. Name Harry E. Kennell

13. Birthplace Allegany, Md.

14. Maiden name Emily E. Evers

15. Birthplace Willsboro, Pa.

16. Informant Mrs. Wm. E. Kennell

Address 62 N. Water, Frostburg, Md.

17. Burial Date thereof 7-14-1946
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Allegany

Location Frostburg, Md.

18. Funeral director Jacob Meyer

Address Frostburg, Md.

19. 7-12 19 46 Mrs. Nancy A. De
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1946 19 46 at 3:15 A M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Dec 1943 to July 12 1946
 and that I last saw him alive on July 11 1946

Immediate cause of death Brain Tumor
Benign - Excised

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Wm. Lane, M.D.

M. D. or other

Address Frostburg, Md. Date signed 7-12-46

RECEIVED

JUL 15 1946

BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

06632

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County... ALLEGANY

City or town... CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs.

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? ONE DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... ALL GANY

City or town... CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street... 506 WARNE STREET
(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

MRS. CLARISSA KERNS

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALE

WHITE

WIDOWED

6. (b) Name of husband or wife... HARVEY KERNS

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) April 7 1970

8. AGE: Years Months Days If less than one day
76 3 12 hrs. min.9. Birthplace... PENNSYLVANIA
(Town, county, and state)

10. Usual occupation... NONE

11. Industry or business

12. Name... WILLIAM P. HOOVER

13. Birthplace... PENNSYLVANIA

14. Maiden name... MCKEE, ELIZABETH

15. Birthplace... PENNSYLVANIA

16. Informant... MEMORIAL HOSPITAL

Address... CUMBERLAND, MARYLAND

17. Burial Date thereof July 17 46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Rose Hill Cem.

Location... Cumberland

18. Funeral director... Louis Stein Inc.

Address... Cumberland

19. Date rec'd by registrar July 16 46 Registrar M. S.

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH... JULY 14 1946 at 10:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-15-46 to July 14, 46

and that I last saw her alive on July 14, 1946

Immediate cause of death... Cerebral Hemorrhage DURATION

Due to... Chronic Hypertension

Due to... Degeneration

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... W.F. Williams M.D.

Address... Cumberland Date signed 7-15-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 23 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(94a)

06633

4

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County... Alli-ganyCity or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 yrs.

Hospital, institution, or street address where death occurred:

627 Quaker Ave.How long in hospital or institution? 3

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State... Maryland County... Alli-ganyCity or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 627 Quaker Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

Edward A. Knight

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Myra V. Foster7. Birth date of deceased (mo., day, yr.) Oct 15 1880 6.(c) If alive, give age... years8. AGE: Years 65 Months 8 Days 25 If less than one day... hrs. ... min.9. Birthplace... Va.
(Town, county, and state)10. Usual occupation... R.R. Conductor11. Industry or business Retired12. Name... Andrew Jackson Knight13. Birthplace Va.14. Maiden name Martha Turner15. Birthplace Va.16. Informant Mrs. Ed. A. KnightAddress Cumberland Ind.17. Burial Date thereof 7/13/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Albans Cem.Location Cumberland18. Funeral director Louis Stein Inc.Address Cumberland19. July 13 46 Registrar W.D. ...
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1946 at 4 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 7 46 to July 10 46 and that I last saw him alive on June 1 46Immediate cause of death coronary occlusion DURATIONDue to arteriosclerosis

Due to

Other conditions myocardial infarction

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Elizabeth ... M.D.Address 7/2/46, Longfield

RECEIVED

JUL 16 1946

BUREAU V. B.

Mr. Geo. Briggs

him

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1640

CERTIFICATE OF DEATH

06634

Reg. Dist. No. 9

1. PLACE OF DEATH:

County AlleganyCity or town Frostburg Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 Months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)Street No. 8 W. Loo St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Jacob Lambert

3. (b) Social Security Number

4. Sex

Male white Married6.(b) Name of husband or wife Mar Armstrong6.(c) If alive, give age 53 years7. Birth date of deceased (mo., day, yr.) Aug. 8th., 18838. AGE: Years 62 Months II Days 9 If less than one day
.....hre.min.9. Birthplace New York, N. Y.
(Town, county, and state)10. Usual occupation Retired11. Industry or business X-Ray technicianFATHER 12. Name Nathaniel Lambert13. Birthplace EuropeMOTHER 14. Maiden name Leah Greenberg15. Birthplace Europe16. Informant Mrs. Jacob LambertAddress 8 W. Loo St. Frostburg, Md.17. Cremation Date thereof July 19 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cedar HillLocation Washington, D. C.18. Funeral director Jacob HaferAddress Frostburg, Md.19. 7-16 19 46 Mrs. Nancy A. Roe
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 19 46 at about

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to 19.....

and that I last saw him Dead July 17 19 46

Immediate cause of death

Bullet wound through head Immediate

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 7-17-46Where did injury occur Frostburg Allegany Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) in a field belowMeans of injury Shot self with Jr. Order Parka 38 caliber revolver. Injured at work?23. SIGNATURE H.V. Deming M.D. H.V. Deming

M. D. or other

Address 225 Bedford St Date signed 7-17-46Deputy Medical Examiner Allegany Co.

RECEIVED

JUL 22 1946

BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1602

CERTIFICATE OF DEATH

06635

Reg. Dist. No. 4

1. PLACE OF DEATH:

County... ALLEGANY

City or town... CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 DAY

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MD. County... ALLEGANY

City or town... CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 108 FOURTH ST.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

McMILLAN, BABY BOY

3. (b) Social Security Number

none

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MALE WHITE SINGLE

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) JULY 3, 1946 @ 5:26 A.M.

8. AGE: Years Months Days If less than one day
1 day 14 hrs. 32 min.

9. Birthplace... MARYLAND
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name... McMILLAN, MERRITT

13. Birthplace... MD.

14. Maiden name... THOMAS, JOANN

15. Birthplace... W. VA.

16. Informant... Merritt E. McMillan

Address... Westwood Sh.

17. Burial (Burial, cremation, or removal, Which?) Date thereof July 5 46
(month) (day) (year)

Cemetery or crematory... Aft. Cem.

Location... Old. Furnace H. Co.

18. Funeral director... Family - Merritt E. McMillan

Address... Cumberburg

19. (Date rec'd by registrar) July 5 46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 3, 1946 at 8:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3 46 to July 3 46 and that I last saw him alive on July 3 46

Immediate cause of death... Prematurity

DURATION 6 1/2 m.

Due to... Ruptured membranes

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

W. P. Hodge, M.D. or other
Cumberburg, Md. Date signed 7/5/46

MARGIN RESERVED FOR BINDING

VS A15-9.45.15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 9 1946
BUREAU V A

Evidence for change of age **MARYLAND STATE DEPARTMENT OF HEALTH**
of deceased is shown on 2411 N. Charles St., Baltimore
Film No. 106 - 7/24/46 **CERTIFICATE OF DEATH**

06636

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 7 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 191 Thomas St.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

William Franklin Merritt

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Divorced

6. (b) Name of husband or wife Bessie Daniels

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1874 6. (c) If alive, give age _____ years

8. AGE: Years 71 72 Months 8 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace Purgittsville, W. Va.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Merchant

12. Name John T. Merritt

13. Birthplace W. Va.

14. Maiden name Esther Hoffman

15. Birthplace W. Va.

16. Informant Mr. Roy Merritt

Address 191 Thomas St. Cumberland, Md.

17. Burial Date thereof July 14, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Lukes Cem.

Location Cumberland, Md.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. July 23 19 46
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 19 46 at 5:35 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 15 to July 11 19 46

and that I last saw him alive on July 4 19 46

Immediate cause of death Coronary thrombosis

Due to 2nd heart attack

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. F. Merritt M. D. or other _____

Address Medical Bldg. Date signed 7/23/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 16 1946
BUREAU V. S.

CERTIFICATE OF DEATH

★ Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

327 Cumberland St./

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 327 Cumberland St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Charles Edward Metz

3. (b) Social Security Number

217-14-4121

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Margaret Metz

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Apr. 21, 1871

8. AGE:

Years

75

Months

2

Days

14

If less than one day

hrs.

min.

9. Birthplace

Cumberland, Md.

(Town, county, and state)

10. Usual occupation

Retired Cashier

11. Industry or business

Bank

FATHER

12. Name

Samuel Metz

13. Birthplace

Maryland

MOTHER

14. Maiden name

Clara Poole

15. Birthplace

Maryland

16. Informant

Mr. John C. Metz

Address

327 Cumberland St. Cumberland, Md.

17.

BurialDate thereof July 7, 1946
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Rose Hill Cem.

Location

Cumberland, Md.

18. Funeral director

Charles L. George

Address

Cumberland, Md.

19.

July 6, 1946

(Date rec'd by registrar)

J. P. Franklin, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4, 1946 at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on July 4, 1946

Immediate cause of death

Arterio-sclerosisHeart diseaseHypertension

Due to

Generalizedarterio-sclerosis

Other conditions

DURATION

4 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations NoneDate of op. NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Wm. F. WilliamsAddress Cumberland Date signed 7-5-46

RECEIVED
JUL 9 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

Evidence for change of year of birth of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 22

CERTIFICATE OF DEATH

Reg. Dist. No. 06638 4

FILM No. 106 AUG 16 1946

1. PLACE OF DEATH:

County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs.

Hospital, institution, or street address where death occurred:
226 Elder St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 226 Elder St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Margaret Jane Nealis

3. (b) Social Security Number

NONE

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife Joseph M. Nealis

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 19 1869 1871

8. AGE: Years Months Days If less than one day
74 7 7 hrs. min.

9. Birthplace Higginsville, W. Va.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name James Haines

13. Birthplace W. Va.

14. Maiden name Hannah Dowden

15. Birthplace W. Va.

16. Informant Joseph M. Nealis

Address Cumberland, Md.

17. Burial Date thereof 7 29 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Ft. Ashby Cem.

Location Ft. Ashby, W. Va.

18. Funeral director Louis Stein, Inc.

Address Cumberland, Md.

19. July 29, 1946 J. P. Frankel, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1946 at 11:00 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 3 1946, to July 19 1946

and that I last saw her alive on July 19 1946

Immediate cause of death

Chronic Myocarditis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geo. P. Penhance M. D. or other

Address Cumberland Md. Date signed 7-27-46

RECEIVED

AUG 2 1946

BUREAU V S.

With corporate filing
Cowherd

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

06639

1. PLACE OF DEATH:

County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegheny Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegheny

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2411 Main Way
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Garey Lynn Norwood

3. (b) Social Security Number

None

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

July 11, 1946

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

001

hrs.

min.

9. Birthplace Cumberland, Allegheny, Md.
(Town, county, and state)10. Usual occupation Infant

11. Industry or business

FATHER

12. Name William L. Norwood13. Birthplace Westernport, Md.

MOTHER

14. Maiden name Dorothy A. Brackey15. Birthplace Cumberland, Md.16. Informant William L. NorwoodAddress Cumberland, Md.17. Burial Date thereof July 12, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose HillLocation Cumberland, Md18. Funeral director John J. J. J.Address Cumberland, Md19. July 13 1946 J. P. Franklin
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1946 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 11 1946 to July 12 1946
and that I last saw him alive on July 12 1946

Immediate cause of death Constitutional
depression -

DURATION

24 hrs.Due to EndocrineDue to regulatoryDue to Constitutional

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

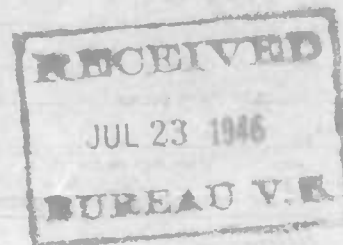
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE J. P. Franklin M. D. or otherDate signed July 13/46



CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlliganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

Alligany HospitalHow long in hospital or institution? One Day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlliganyCity or town Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. Horseshoe Addition
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Susan A. O'Neal

3.(b) Social Security Number

None4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Benjamin T. O'Neal6.(c) If alive, give age 46 years7. Birth date of deceased (mo., day, yr.) May 12 18838. AGE: Years 63 Months 2 Days 4 If less than one day
.....hrs.min.9. Birthplace Hancock Ind.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Joseph Larkick13. Birthplace Maryland14. Maiden name Eva Grace15. Birthplace Maryland16. Informant Robertson O'NealAddress Cumberland, Md.17. Burial Date thereof 7/19/46
(Burial, cremation, or removal) Which? (month) (day) (year)Cemetery or crematory Rose Hill Cem.Location Cumberland, Md.18. Funeral director Louis Stern Inc.Address 117 Frederick St. Cumb. Md.19. July 19 46 19 46
(Date rec'd by registrar)Registrar Joseph G. FrankAddress M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 19 46 at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 18 19 46 to July 15 19 46and that I last saw him alive on July 15 19 46Immediate cause of death accidental

DURATION

Chronic MyocarditisDue to Chronic Myocarditis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Chronic MyocarditisStone in cystic duct Date of July 13-46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature J. G. Frank

M. D. or officer

Date signed 7/19/46

RECEIVED
JUL 23 1946
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 875 Ridgedale ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial (Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. July 27, 1946

(Date rec'd by registrar)

J. P. Frankel, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 July 46 19 46 at 2 25 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 25 July 46 to 25 July 46 and that I last saw him alive on 25 July 46 19 46

Immediate cause of death

Coronary thrombosis

DURATION

30 min

Due to

acute cholelithiasis3 wks

Due to

Peritonitis with effusion2 wks

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. Alfred V. ...Address 110 S. Center St. CityDate signed 26 July 46

RECEIVED
JUL 30 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

Reg. Dist. No. 06642 10

1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

Date thereof

(Burial, cremation, or removal. Which)

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. July 26

Date read by registrar

19 46

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 24th

19 46

at

7:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 22

19 46

and that I last saw him

alive on

July 22

19 46

Immediate cause of death

Cerebral Hemorrhage

DURATION

Immediate

Due to

Due to

Other conditions

Vascular Hypertension

Arterio Sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William E. Mosley, M.D.

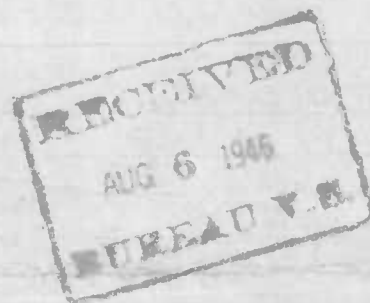
M.D. or other

Address

Mt. Savage, Md.

Date signed

July 26 46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06643

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 hours

Hospital, institution, or street address where death occurred:

Allegheny HospitalHow long in hospital or institution? 5 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa County BedfordCity or town Bedford
(If outside city or town limits, write RURAL and give nearest town)Street No. Rt. 3
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Thomas Eugene Perden

3. (b) Social Security Number

None4. Sex M5. Color or race W6. (a) Single, married, widowed, or divorced single

8. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) February 9, 19468. AGE: Years 0 Months 5 Days 5 If less than one day _____ hrs. _____ min.9. Birthplace Cumberland, Allegheny, Md.
(Town, county and state)10. Usual occupation In farm

11. Industry or business

12. Name Marvin Perden13. Birthplace Beans Cove, Pa.14. Maiden name Eleanor Miller15. Birthplace Bedford, Pa.16. Informant Marvin PerdenAddress Rt. 3, Bedford, Pa.17. Burial Date thereof July 17, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Beans Cove Methodist CemeteryLocation Beans Cove, Pa.18. Funeral director John J. HofferAddress Cumberland, Md.19. July 16 1946 J. P. Franklin
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-14-46 at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7-14-46 to 7-14-46and that I last saw him alive on 7-14-46Immediate cause of death gastro-enteritisDURATION 3 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. H. Hoffer MD
Long M. Hoffer M. D. or otherAddress Long M. Hoffer Date signed 7-18-46

RECEIVED
JUL 23 1946
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County..... Allegany
City or town..... Westernport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 16 years
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Allegany
City or town..... Westernport
(If outside city or town limits, write RURAL and give nearest town)
Street No..... 410 Maryland Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Monira Phillips
4. Sex..... Female 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Married
6.(b) Name of husband or wife..... John Phillips
6.(c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.)..... 3 June 1859
8. AGE: Years..... 87 Months..... 0 Days..... 28 It less than one day..... hrs. min.

9. Birthplace..... Lonaconing-Allegany-Maryland
(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business..... own home

12. Name..... William Miller

13. Birthplace..... Lonaconing, Maryland

14. Maiden name..... Dorcas Duckworth

15. Birthplace..... Lonaconing, Maryland

16. Informant..... Leslie T. Foote

Address..... Lonaconing, Maryland

17. Burial..... Date thereof..... 3 July 1946
(Burial, cremation, or removal. Which?)..... (month) (day) (year)

Cemetery or crematory..... Morrisons Cemetery

Location..... Near Boulton, Md.

18. Funeral director..... Ellsworth S. Boal

Address..... 111 Church St, Westernport, Md.

19. Date rec'd by registrar..... July 7 46 Registrar.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 1 July 1946 19..... 21. 3:00p.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1946 to July 1, 1946

and that I last saw him alive on July 1, 1946

Immediate cause of death..... Carcinoma of Stomach

DURATION..... 2 mos

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... J. Norman Reeves, M.D. M.D. or other

Address..... Westernport, Md. Date signed..... 7-1-46

RECEIVED
JUL 3 1946
BUREAU V S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

06645

1. PLACE OF DEATH

County Allegany Registration Dist. No. 4
 Village or City Cumberland No. 109 Grand Avenue Ward
 (If death occurred in a hospital or institution, give its NAME instead of street and number)
 Length of residence in city or town where death occurred 3 yrs. 6 mos. 0 ds. How long in U. S. if of foreign birth? 0 yrs. 0 mos. 0 ds.

2. FULL NAME

(a) Residence: No. 109 Grand Ave St. Grand Ward. Grand
 (Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Louise Pomeroy

6. DATE OF BIRTH (month, day, and year) Jan. 28, 1860

7. AGE Years 86 Months 5 Days 14 If LESS than 1 day, 0 hrs. 0 min.

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Retired
 9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Lumberman
 10. Date deceased last worked at this occupation (month and year) 1931 11. Total time (years) spent in this occupation 60

12. BIRTHPLACE (city or town) Front Royal (State or country) Virginia

13. NAME Richard Newton Pomeroy

14. BIRTHPLACE (city or town) Virginia (State or country)

15. MAIEN NAME Margaret (?)

16. BIRTHPLACE (city or town) Virginia (State or country)

17. INFORMANT Raymond S. Pomeroy (Address)

18. BURIAL, CREMATION, OR REMOVAL Place Loc Hill, Hagerstown, Md. July 15, 1946

19. UNDOERTAKER C. M. Sullivan & Sons (Address) 1433 Va. Ave.

20. FILED July 12, 1946 J. P. Franklin, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH July 12, 1946
 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from July 8, 1946, to July 12, 1946

Last saw him alive on July 18, 1946; death is said to have occurred on the date stated above, at 1 P.M.

The PRINCIPAL CAUSE OF DEATH and related causes of Importance were as follows:

arterio sclerosis
coronary occlusion
general debility

Date of onset

Other Contributory Causes of Importance: suppuration of artery

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of Injury _____, 19____

Where did injury occur? _____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) MEB Owens M. O.

(Address) 133 Va. Ave.

MARGIN RESERVED FOR BINDING

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as “employee,” “worker,” “operative,” etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as “store,” “factory,” “mill,” etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term “laborer” when a more precise statement of the occupation can be secured. Do not use the word “mechanic,” but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>11 16 1946</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

06646
Reg. Dist. No.

4

1. PLACE OF DEATH:

County... Allegheny
City or town... East Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 17 years
Hospital, institution, or street address where death occurred:
Emmortal HospitalHow long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Allegheny
City or town... Cumtberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 504 Cumberland St.
(If rural, give LOCATION)

2(a) If veteran, name war.....

3. (a) FULL NAME

John Wesley Reitz

3. (b) Social Security Number

714-05-72294. Sex Male 5. Color of race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife... Margaret C Baker7. Birth date of deceased (mo., day, yr.) May 25, 1874 6. (c) If alive, give age..... years8. AGE: Years 72 Months 1 Days 23 If less than one day..... hrs. min.9. Birthplace... Smithsboro Pa.
(Town, county, and state)10. Usual occupation... Salesman

11. Industry or business

12. Name... John C Reitz Pa.13. Birthplace Mary Knontz14. Maiden name... Pa.15. Birthplace Pa.16. Informant Mrs Margaret B. Reitz
Address Cumtberland17. Funeral Date thereof July 21, 46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Maple Hill Cem.
Location Elkins N. Va18. Funeral director Louis Stein
Address Cumtberland19. July 23 19 46 Joseph P. Dobbins
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 19 46, at 10:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 19 46, to July 18 19 46, and that I last saw him alive on July 18 19 46

Immediate cause of death..... DURATION

Coronary
Due to Thrombosis None

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations... None Date of op. NoneAutopsy results... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

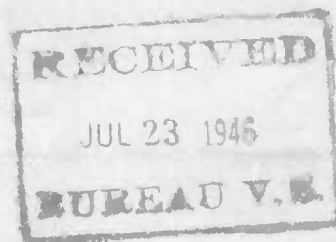
23. SIGNATURE J. F. Williams M. D. or otherAddress Cumtberland Date signed 7-14-46

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06647

DR DURRETT

CERTIFICATE OF DEATH

★ Reg. Dist. No. 4

1. PLACE OF DEATH:

County... ALLEGANYCity or town... CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County GARRETTCity or town... FRIENDSVILLE
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2(a) If veteran, name war... ✓

3. (a) FULL NAME

BABY BOY SCHROYER

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALEWHITE

6. (b) Name of husband or wife

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) JUNE 29, 19468. AGE: Years Months Days If less than one day
2 hrs. min.9. Birthplace Cumberland, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name LAKIN SCHROYER13. Birthplace Hazleton, W. Va.14. Maiden name MARY JANE SUTER15. Birthplace Garrett Co., Md.16. Informant MEMORIAL HOSPITALAddress CUMBERLAND MD.17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
July 2, 1946Cemetery or crematory Suter CemLocation Hoyes Cem18. Funeral director W. W. SavageAddress Friendsville, Md.

19. Date rec'd by registrar July 1, 1946 J. P. Traubling, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 1, 1946 at 12:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 June 1 to June 30 19 46
and that I last saw alive on June 30 19 46Immediate cause of death Pneumonia

DURATION

Due to Arthur Bede -Due to respirable by pneumonia

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clayton L. Lerner M.D. or otherAddress Cumberland Date signed July 1, 1946

MARGIN RESERVED FOR BINDING

VS A15 9.45.15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ARTISTIAN 12023

WAS CONTENT

RECEIVED
JUL 9 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 06648 9

1. PLACE OF DEATH:

County..... Allegany
 City or town..... Frostburg
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Miners' hospital
 How long in hospital or institution?..... 2 weeks

3. (a) FULL NAME

James Leonard Seggie

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Ida Seggie

7. Birth date of deceased (mo., day, yr.)

May 12, 1919

8. AGE:

Years

27

Months

1

Days

27

If less than one day

hrs. min.

9. Birthplace

Meyersdale, Somerset, Penna.

(Town, county, and state)

10. Usual occupation

Engineer

11. Industry or business

Coca-cola Plant

12. Name

Edward Seggie

13. Birthplace

Pennsylvania

14. Maiden name

unknown

15. Birthplace

unknown

16. Informant

Mrs. Ida Seggie

Address

Frostburg, Md.

17. Burial

(Burial, cremation, or removal. Which?)

St. Michael's Cemetery

Location

Frostburg, Md.

18. Funeral director

J. R. Dietz

Address

Frostburg, Md.

19. 7-11

(Date rec'd by registrar)

19. 46

Mrs. Nancy H. Doe

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... AlleganyCity or town..... Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 130 Mt. Pleasant St.

(If rural, give LOCATION)

2. (a) If veteran, name war..... World War II (*)

3. (b) Social Security Number

172-18-3251

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 9 1946, at 8:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 15 1946 to July 9 1946and that I last saw him alive on July 9 1946

Immediate cause of death.....

Infectious hepatitis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... N. E. Gortner M.D.Address..... Frostburg, Md.Date signed..... 7/10/46

RECEIVED
JUL 15 1946
BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

I. PLACE OF DEATH:

County Allegany
 City or town Chamberland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany
 City or town Flintstone
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Rt. 2

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Baby Girl Self

3. (b) Social Security Number

None

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 17, 1946 8. (c) If alive, give age _____ years

8. AGE: Years _____ Months _____ Days _____ If less than one day 7 hrs. 45 min.

9. Birthplace Chamberland, Allegany, Maryland
 (Town, county, and state)

10. Usual occupation Infant

11. Industry or business

12. Name Alvin Self13. Birthplace Grant Co. W. Va.14. Maiden name Ruth Sommerville15. Birthplace W. Va.16. Informant Alvin SelfAddress Rt. 2, Flintstone, Md.

17. Burial Date thereof July 19, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Brothers CemeteryLocation Flintstone, Md.18. Funeral director John J. WafarAddress Chamberland, Maryland

19. July 19, 46 20. Dr. A. H. Hines
 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 19 46 at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 17 19 46 to July 17 19 46
 and that I last saw him alive on July 17 19 46

Immediate cause of death

Premature baby

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

Dr. A. H. Hines MD

M. D. or other

Address

Long Run

Date signed

2-18-46

RECEIVED
JUL 23 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

06650 4

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 yrs

Hospital, institution, or street address where death occurred:

405 Maryland Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 405 Maryland Ave.
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Effie Belle Shatzer

3. (b) Social Security Number

None4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married8. (b) Name of husband or wife Carl E. Shatzer

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 2 18858. AGE: Years 61 Months 1 Days 24 If less than one day _____ hrs. _____ min.9. Birthplace Rush Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business _____

12. Name Samuel F. Wilson13. Birthplace Md.14. Maiden name Maria S. Smith15. Birthplace Md.16. Informant Carl E. ShatzerAddress Cumberland17. Burial (Burial, cremation, or removal) Which? Date thereof July 28 '46
(month) (day) (year)Cemetery or crematory Rose Hill Cem.Location Cumberland18. Funeral director Louis Stein Inc.Address Cumberland19. July 28 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1946 at 11:15 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1931, to 7-26 1946and that I last saw her alive on 7-25-46 1946

Immediate cause of death _____

Scatops helictus DURATION 18 yrs

Due to _____

Due to _____

Other conditions Myocarditis 1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Samuel F. Wilson M.D. or other _____Address Cumberland Date signed 7-26-46

RECEIVED

AUG 2 1946

BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-1

CERTIFICATE OF DEATH

Dr. Wolverton, Jr.

066516

Reg. Dist. No.

1. PLACE OF DEATH:

County AlleganyCity or town Barton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Barton
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

John Algen Shook

3.(b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Emma Shook6.(c) If alive, give age 51 years7. Birth date of deceased (mo., day, yr.) 27 August 18768. AGE: Years 69 Months 10 Days 24 It less than one day
..... hrs. min.9. Birthplace Cresaptown-Allegany-Maryland
(Town, county, and state)10. Usual occupation Miner11. Industry or business Coal Mine12. Name John W; Shook13. Birthplace Pennsylvania

14. Maiden name

15. Birthplace

16. Informant Mrs John ShookAddress Barton, Maryland17. Burial (Burial, cremation, or removal. Which?) 24 July 1946
(month) (day) (year)Cemetery or crematory Biertown CemeteryLocation Rawlings, Maryland18. Funeral director Ellsworth S. BoalAddress 111 Church St, Westernport, Md.19. July 24 19 46 Paynter
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 July 19 46 4:10 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 July 19 46 to 21 July 19 46 and that I last saw him alive on 20 July 19 46Immediate cause of death Cerebral Hemorrhage DURATION 12 hoursDue to Hypertensive cardio-vascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James W. Wolverton Jr. MD M.D. or otherAddress Piedmont W.Va. Date signed July 24, 1946

RECEIVED

JUL 26 1946

BUREAU V &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

CERTIFICATE OF DEATH

06652

Reg. Dist. No. 5-

1. PLACE OF DEATH:

County Allegany
City or town Rural Cumberland, Rt. #3 Keyser
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Rural Cumberland, Rt. #3 Keyser, W. Va

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Rural Cumberland, Rt. #3 Keyser
(If outside city or town limits, write RURAL and give nearest town)

Street No. Near Cumberland

(If rural, give LOCATION)

2.(c) If veteran, name war.

3. (a) FULL NAME

Rezin Hansford Simpson

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Sophia Feaster Simpson

7. Birth date of

deceased (mo., day, yr.)

June 9, 1870

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

76112

hrs.

min.

9. Birthplace Woodland, Beth Co. Virginia

(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name George Simpson13. Birthplace Virginia14. Maiden name Mary Ann Cleek15. Birthplace Virginia16. Informant Mrs. Sophia SimpsonAddress Rt. #3 Keyser, W. Va.17. Burial Date thereof July 23, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Dawson Cem.Location Near Dawson, Md.18. Funeral director H. Wayne GeorgeAddress Cumberland, Md.19. 7/23 19 46

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21, 1946 19 46 at 12:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 4, 1946 to July 21, 1946and that I last saw him alive on July 16, 1946

Immediate cause of death

Myocarditis

DURATION

1 hr

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Geo. P. Paulman

M. D. or other

Address Date signed 7/23/46

RECEIVED

JUL 26 1946

BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 332

CERTIFICATE OF DEATH

Reg. Dist. No. 06653 4

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? yes
 Hospital, institution, or street address where death occurred:
223 Schley St
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 223 Schley St
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Fannie Christine Stein

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Garris Stein

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4 1858

8. AGE: Years 88 Months 2 Days 2 If less than one day hrs. min.

9. Birthplace Kansas City Missouri
 (Town, county, and state)

10. Usual occupation

11. Industry or business Housewife

12. Name Adam Kogel

13. Birthplace Germany

14. Maiden name Catherine Kruft

15. Birthplace Germany

16. Informant Frank A Stein

Address Cumberland Maryland

17. Mausoleum Date thereof July 8 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Mausoleum

Location Payette St Cumberland Md

18. Funeral director Fanis Stein Inc

Address Cumberland Md

19. July 8 19 46 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July - 6 1946 at 3:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 - 1946 to July 6 1946 and that I last saw him alive on July 6 1946

Immediate cause of death Cerebral Thrombosis

DUE TO Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. P. Franklin M.D. M. D. or other

Address 1267 Union St Cumberland Md Date signed 7/7/46

MARGIN RESERVED FOR BINDING

VS A15 9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 16 1946

BUREAU V.E.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital
How long in hospital or institution? one day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Garrett
City or town Grantsville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

Mr. Clark. M. Swauger

3.(b) Social Security Number

220-03-3803

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MaleWhiteSingle

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Dec. 7, 1915

8. AGE:

Years

Months

Days

If less than one day

30715

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Plumbers Helper

11. Industry or business

Union Fire Brick Co.

FATHER

12. Name

Swauger, John

13. Birthplace

Maryland

MOTHER

14. Maiden name

Hare, Lillie

15. Birthplace

Maryland

16. Informant

Memorial Hospital

Address

Cumberland, Maryland

17.

(Burial, cremation, or removal. Which?)

Date thereof

7-24-1946
(month) (day) (year)

Cemetery or crematory

Bethlehem

Location

Bethlehem

18. Funeral director

Wm. Winkler

Address

Francisville

19.

(Date rec'd by registrar)

July 24, 1946J. P. Franklin, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 22, 1946 at 4:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 22, 1946 to July 22, 1946
and that I last saw him alive on July 22, 1946

Immediate cause of death

Cranial fracture
7 ft. fall

DURATION

Due to

Fall while working

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. D. Gracie

M. D. or other

Address

CumberlandDate signed July 24

LETTER TO THE CHIEF OF BUREAU

RECEIVED

RECEIVED

JUL 30 1946

BUREAU V.B.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06655

DR. WILLIAMS

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....ALL EGANY

City or town.....CHIMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....W.VA. County.....HAMPSHIRE

City or town.....ROMNEY
(If outside city or town limits, write RURAL and give nearest town)

Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

MISS MARGARET TAYLOR

4. Sex.....5. Color or race.....6.(a) Single, married, widowed, or divorced

FEMALE WHITE SINGLE

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....6.(c) If alive, give age.....years

DEC. 25, 1877

8. AGE: Years.....Months.....Days.....If less than one day

68 6 21 hrs.min.

9. Birthplace.....W.VA.
(Town, county, and state)

10. Usual occupation.....RETIRED REGISTERED NURSE

11. Industry or business.....

12. Name.....JOHN TAYLOR

13. Birthplace.....W.VA.

14. Maiden name.....ANNIE WILSON

15. Birthplace.....N. CAROLINA

16. Informant.....Memorial Hospital
Address.....Chimberland, Maryland

17. (Burial, cremation, or removal. Which?).....Date thereof.....July 19-46.
(month) (day) (year)

Cemetery or crematory.....Indian Mound

Location.....Romney W.VA.

18. Funeral director.....Thrush's

Address.....Romney W.VA.

19. Date rec'd by registrar.....July 17, 1946.....R. Franklin Registrar

3.(b) Social Security Number

None

MEDICAL CERTIFICATION

10:55 P.M.

20. DATE OF DEATH.....JULY 16, 1946.....19.....al.....M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16, 1946 to July 16, 1946

and that I last saw him alive on July 16, 1946

Immediate cause of death.....

.....DURATION

Due to.....

Due to.....

Other conditions.....

.....(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide.....Date of

Where did injury occur?.....(City or town).....(County).....(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....Injured at work?

23. SIGNATURE.....

Address.....M. D. or other

Date signed.....

MARGIN RESERVED FOR BINDING

I

VS A15

9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 23 1946
BUREAU V B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

00656
Reg. Dist. No.

1. PLACE OF DEATH:

County..... Allegany
 City or town..... Flintstone
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

For new born infants give residence of mother
Maryland Allegany
 State..... County.....
 City or town..... Flintstone
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Charles H. Tressler

3. (b) Social Security Number

214-16-2173

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Florence May Porter

Tressler

45

7. Birth date of deceased (mo., day, yr.)

August 13, 1892

6. (c) If alive, give age..... years

8. AGE:

Years
53Months
11Days
6

If less than one day

..... hrs. min.

8. Birthplace

Somerset County, Penna.

(Town, county, and state)

10. Usual occupation

Celanese Employee

11. Industry or business

FATHER
 12. Name..... George W. Tressler
 13. Birthplace..... Penna.

MOTHER
 14. Maiden name..... Susan Bittner
 15. Birthplace..... Sandpatch, Pa.

18. Informant

Mrs. Florence Tressler

Address

Flintstone, Md.

17. Burial

Date thereof July 22, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or place of burial..... White OakLocation Meyersdale, Penna.

18. Funeral director

Harvey H. Zeigler

Address

Hyndman, Penna.

19. July 21 19 46
 Date rec'd by registrar

Nina S. Bender
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 19 19 46 at 3:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 19 45 to July 19 46and that I last saw him alive on July 19 19 46

Immediate cause of death

Cerebral sclerosis

DURATION

10 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE

John A. Topper M.D.
Hyndman, Pa.
 Address..... Date signed 7/20/46

RECEIVED
JUL 24 1948
U.S. AIR FORCE

STATE OF MARYLAND—CERTIFICATE OF DEATH 06657

1. PLACE OF DEATH

County AlleghenyVillage or City CumberlandNo. Memorial Hospital St. 4 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 1 1/2 yrs. 4 mos. 0 ds.How long in U.S. if of foreign birth? 0 yrs. 0 mos. 0 ds.

2. FULL NAME

Samuel T. Van Horn(a) Residence: No. High St.; Meyersdale, Pa. Ward ✓

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Married

5a. If married, widowed, or divorced

HUSBAND of (or) WIFE of

Bessie Lute Van Horn

6. DATE OF BIRTH (month, day, and year)

Sept. 3, 1878

7. AGE

Years

67

Months

10

Days

16

If LESS than

1 day, 0 hrs. 0 min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

Retired Signal Maintainer

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

of W. Maryland R.A.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town)

(State or country)

Virginia

FATHER

13. NAME

Benjamin F. Van Horn

14. BIRTHPLACE (city or town)

(State or country)

Virginia

MOTHER

15. MAIDEN NAME

Elizabeth Underwood

16. BIRTHPLACE (city or town)

(State or country)

Virginia

17. INFORMANT

(Address)

Samuel T. Van Horn
Meyersdale, Pa.

18. BURIAL, CREMATION, OR REMOVAL

Place

Meyersdale, Pa.

Date

July 31, 1946

19. UNDERTAKER

(Address)

William R. Fusi
Meyersdale, Pa.

20. FILED

July 18, 1946J. B. Franklin M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

7 - 19 - 1946
(Month) (Day) (Year)

22.

I HEREBY CERTIFY, That I attended deceased from 5-24-46 to 7-19-46I last saw him alive on 7-18-461946; death is said to have occurred on the date stated above, at 550 m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Date of onset

Myocardial degeneration

Other Contributory Causes of importance:

Benign hypertrophy prostate
Chronic nephritis

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy? yes

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?

Date of injury 19

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

(Address)

Howard J. Tolson
Cumberland, Md. M. D.

MARGIN RESERVED FOR BINDING

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
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Example II

The principal cause of death and related causes of importance were as follows:

<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 19 days

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pennsylvania County SomersetCity or town Berlin
(If outside city or town limits, write RURAL and give nearest town)Street No. 189 Broadway
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mildred Walker

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife H. Wallace WalkerB. (c) If alive, give age 61 years7. Birth date of deceased (mo., day, yr.) January 25, 1898

8. AGE: Years Months Days If less than one day

48526

hrs. min.

9. Birthplace Pennsylvania

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Albert Rhoads13. Birthplace Pennsylvania14. Maiden name Annie M. Hauger15. Birthplace Pennsylvania16. Informant H. Wallace WalkerAddress Berlin, Penna.17. Burial Date thereof July 24, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory I. O. O. F. Cem.Location Berlin, Penna.18. Funeral director W. A. JohnsonAddress Berlin, Penna.19. July 22, 1946 J. P. Franklin, M. D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21, 1946, 8:40 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19... to 19...

and that I last saw him alive on 19...

Immediate cause of death Shock

DURATION

Following operationfor removal of obstructedabout July 14, 1946

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Mechanical obstructionDate of op. 7-21-46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

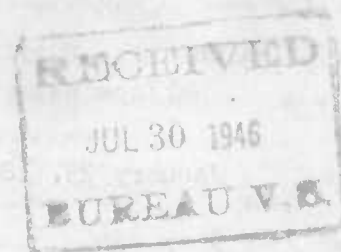
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. P. Franklin

M. D. or other

Address Cumberland Date signed 7-22-46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1646)

06659

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

C. & O. Canal

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 32 Blackstone Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Mrs. Anna M. Weimer

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female white married6. (b) Name of husband or wife John Weimer6. (c) If alive, give age 53 years7. Birth date of deceased (mo., day, yr.) Sept. 26, 18928. AGE: Years Months Days If less than one day
53 9 29 hrs. min.9. Birthplace Cooks Mills, Penna.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name George Wilhelm13. Birthplace Penna.14. Maiden name Clara Troutman15. Birthplace Penna.16. Informant Mr. John R. WeimerAddress 32 Blackiston Ave. Cumberland, Md17. Burial Date thereof July 28, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cooks Mills Cem.Location Cooks Mills Penna.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.19. July 27, 1946 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 19 46 about A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to 19.....

and that I last saw h er Dead July 25 19 46

Immediate cause of death

Suicide by drowning Immediately

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 7-25-46Where did injury occur? Cumberland Allegany Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) C & O Canal

Means of injury

Injured at work?

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or other

Address Date signed

Acting

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 30 1946

BUREAU V S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

06660

1. PLACE OF DEATH:

County Allegheny
City or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 11 hours 50 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State West Virginia County Hardy
City or town Moorefield
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2(a) If veteran, name war _____

3. (a) FULL NAME

Frank N. Welton

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) May 15, 1954 6. (c) If alive, give age _____ years

8. AGE: Years 92 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace West Virginia
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER 12. Name Felix Welton
13. Birthplace West Virginia

MOTHER 14. Maiden name Sally Nelson
15. Birthplace Virginia

16. Informant Memorial Hospital
Address Cumberland, Maryland

17. Burial Date thereof July 15, 1954
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Welton
Location Near Surgeon, Va.

18. Funeral director Thrush
Address Moorefield, W. Va.

19. July 15 19 54
(Date rec'd by registrar) Registrar Joseph O. Smith, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-13-1946 7:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-13-1946 to 7-13-1946 and that I last saw him alive on 7-13-1946

Immediate cause of death Infirmities of age DURATION _____

Due to no further information

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. None

Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. F. Williams
M. D. or other _____
Address Cumberland Date signed 7/15/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF CONNECTICUT

OFFICE OF THE ATTORNEY GENERAL

PLEASE DO NOT WRITE

STATE OF CONNECTICUT

1946

RECEIVED
JUL 23 1946
BUREAU V.A.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1526

06661

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 HOURS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 8 HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. 154 N. CENTRE STREET
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

MRS. JOSEPHINE WHETSTONE

3. (b) Social Security Number

220-07-6387

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

FEMALE WHITE MARRIED6.(b) Name of husband or wife EARL WHETSTONE8.(c) If alive, give age 34 years7. Birth date of deceased (mo., day, yr.) JANUARY 11, 19168. AGE: Years Months Days If less than one day
30 6 3 hrs. min.9. Birthplace WEST VIRGINIA
(Town, county, and state)10. Usual occupation HOUSE WIFE

11. Industry or business

12. Name EARL COMBS13. Birthplace MARYLAND14. Maiden name JOSEPHINE SAILEY15. Birthplace PENNSYLVANIA16. Informant MEMORIAL HOSPITALAddress CUMBERLAND, MARYLAND17. Burial Date thereof July 17, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. Olive Cem.Location Near Manns Choice, Penna.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.19. July 16 19 46 J. C. Bradley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 14 19 46 at 2:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7/13/46 19 46 to 7/14/46 19 46and that I last saw her alive on 7/14/46 19 46Immediate cause of death Myasthenia Gravis

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. C. Bradley M. D. or otherAddress Med. Bldg. Date signed 7/15/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 23 1946
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 75-6

CERTIFICATE OF DEATH

00062

Reg. Dist. No. 9

1. PLACE OF DEATH:

County AlleganyCity or town Smethport
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Smethport
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Mrs. Leona Whitehead

3. (b) Social Security Number

215-20-72374. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Harold Whitehead7. Birth date of deceased (mo., day, yr.) Feb 25-1925 6. (c) If alive, give age 24 years8. AGE: Years 21 Months 4 Days 7 If less than one day _____ hrs. _____ min.9. Birthplace Behlert-Alleg-Md.
(County, and state)10. Usual occupation Clerk (retired)11. Industry or business Confectionery12. Name Wm. Leslie Snyder13. Birthplace Behlert, Md.14. Maiden name Margaret Wright15. Birthplace Md.16. Informant Leslie SnyderAddress 3 Southport Rd.17. Burial Date thereof July 6-1946
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory BehlertLocation Behlert, Md.18. Funeral director J. J. DelastAddress 3 Southport Rd.19. 7-6 19 46 Mr. Nancy N. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 19 46, at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19 _____, to _____ 19 _____, and that I last saw him alive on June 3 19 46

Immediate cause of death

Fractured skull
frontal bone

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of 7-3-1946Where did injury occur? Smethport Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) his homeMeans of injury Pushing bag, boxes Injured at work?ran away, she was thrown to ground23. SIGNATURE N. N. Roe M. D. or other _____Address 125 Bedford St. Date signed 7-3-46
Deputy Medical Examiner - Allegany Co.

RECEIVED

JUL 9 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on age of deceased is shown on

is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate jurisdiction for the change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

FILM No. 106 JUL 17 1946

06663 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 yrs.
 Hospital, institution, or street address where death occurred:
482 Williams St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)
 State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 482 Williams St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mary Rose Wigger

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife J. Bernard Wigger
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Nov. 19, 1876
 8. AGE: Years 69 Months 10 Days 14 If less than one day _____ hrs. _____ min.

9. Birthplace Romney, W. Va.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Philip Shank
 13. Birthplace West Va.
 14. Maiden name Rebecca Miner
 15. Birthplace West Va.

16. Informant Vincent D. Wigger
 Address 482 Williams St.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof July 6, 1946
 (month) (day) (year)
 Cemetery or crematory St. Patrick's Km.
 Location Cumberland, Md.

18. Funeral director Louis Therese
 Address Cumberland Md.

19. Date rec'd by registrar July 6, 1946 J. P. Franklin, M.D.
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 19 46 at 7:52 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 19 44 to July 3 19 46
 and that I last saw him alive on July 2 19 46

Immediate cause of death Carcinoma of uterus
 DURATION 9/144

Due to Carcinoma of uterus
 Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations As above
 Date of op. 9/144

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE E. J. Franklin M. D. or other July 3, 1946
 Address _____ Date signed _____

Please sign

+ put on

mantle

Steen

RECEIVED

JUL 9 1946

BUREAU V. K.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. P. E. Berry

00064

Reg. Dist. No. 6

1. PLACE OF DEATH:

County... AlleganyCity or town... Westernport
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 months

Hospital, institution, or street address where death occurred:

Hill top Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... AlleganyCity or town... Frodsburg
(If outside city or town limits, write RURAL and give nearest town)Street No. 152 Green Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Raymond Ellsworth Wilson

3. (b) Social Security Number

216-07-8104

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife... Leila Wilson6.(c) If alive, give age 30 years7. Birth date of deceased (mo., day, yr.) 20 January 1905

8. AGE: Years Months Days If less than one day

41

6

0

hrs.

min.

9. Birthplace... Westernport-Allegany-Maryland
(Town, county, and state)10. Usual occupation... Laborer11. Industry or business... Electric Plant12. Name... John Wilson13. Birthplace... Westernport, Maryland14. Maiden name... Louise Holler15. Birthplace... Hyndman, Penna16. Informant... Mrs John WilsonAddress... Westernport, Maryland17. Burial... Burial Date thereof... 22 July 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Philos CemeteryLocation... Westernport, Maryland18. Funeral director... Ellsworth S. BoalAddress... 111 Church St. Westernport, Md.19. July 22 1946 W. A. Baker M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH... 20 July 1946 at 5:45pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept - 1 1946 to July 20 1946and that I last saw him alive on July 20 1946Immediate cause of death... Carcinoma Bladder

DURATION

2 yrs

Due to...

Due to...

Other conditions... History Stone

(Include pregnancy within 8 months of death)

Major findings of operations...

Date of op...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... P. E. Berry M.D.Address... Piedmont W. Va Date signed... 7/22/46

RECEIVED
JUL 23 1946
BUREAU OF

Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06665

Reg. Dist. No.

4

1. PLACE OF DEATH:

County Allegany

City or town Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

R.D.#4 Uhl Highway

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.D.#4 Uhl Highway
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Rachel Ann Wolford

3.(b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife George H. Wolford

B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept. 25, 1881

8. AGE:

Years

Months

Days

if less than one day

64

9

12

hrs.

min.

9. Birthplace Plum Run W. Va.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name John W. Malone

13. Birthplace Fort Ashby, W. Va.

MOTHER

14. Maiden name Mary E. Culp

15. Birthplace Fort Ashby, W. Va.

18. Informant Mr. Oscar Wolford

Address R.D.#4 Cumberland, Md.

17. Burial Date thereof July 10, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Malone Cemetery

Location Near Fort Ashby, W. Va.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. July 9, 1946 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 1946 at 7 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw her Dead on 19.

Immediate cause of death

Coronary thrombosis

DURATION

Immediately

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE J. P. Franklin M.D. M. D. or other

Address 125 R. 4th St Date signed 7/9/46

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 16 1946

BUREAU V.E.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-2)

CERTIFICATE OF DEATH

00666

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County AlleghenyNear town Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. Rt. 3

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

Emma Jane Wraichford

3.(b) Social Security Number

None4. Sex F5. Color or race W

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Robert C. Wraichford7. Birth date of deceased (mo., day, yr.) October 17, 18806.(c) If alive, give age 66 years8. AGE: Years 65 Months 8 Days 29

If less than one day

hrs. min.

9. Birthplace Buchanan, Upshur, W. Va.

(Town, county, and state)

10. Usual occupation Housewife11. Industry or business Own homeFATHER 12. Name John Lewis13. Birthplace W. Va.MOTHER 14. Maiden name Laverna Ward15. Birthplace W. Va.16. Informant Robert C. WraichfordAddress Rt. 3, Cumberland, Md17. Burial Date thereof July 19, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Zion Memorial ParkLocation Cumberland, Md.18. Funeral director John J. WraichAddress Cumberland, Md19. July 19 1946 Registrar M. O.

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 19 46 at 3:05 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

July 16 19 46 to July 16 19 46and that I last saw or alive on July 16 19 46Immediate cause of death Carcinoma of Cervix

DURATION

2 yr

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. _____ Date of _____

Where did injury occur? _____

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. R. Hodges, M.D.Address Cumberland, Md Date signed 7/17/46

D. or other _____

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10000

UNITED STATES DEPARTMENT OF JUSTICE
BUREAU OF INVESTIGATION
WASHINGTON, D. C.

MEMORANDUM FOR THE DIRECTOR

SUBJECT: [Illegible]

RECEIVED
JUL 23 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

CERTIFICATE OF DEATH

Reg. Dist. No. 06667 4

1. PLACE OF DEATH:

County AlleganyCity or town Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

R.D.#4

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. R.D.#4
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Emma Jane Young

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1869

8. AGE:

Years

Months

Days

If less than one day

761024

hrs.

min.

9. Birthplace Hagerstown, Md.
(Town, county, and state)10. Usual occupation Retired11. Industry or business Dye Worker

FATHER

12. Name Robert L. Young13. Birthplace Penna.

MOTHER

14. Maiden name Sarah Ward15. Birthplace Penna.16. Informant Mrs. Louella GoldenAddress R.D.#4 Cumberland, Md.17. Burial Date thereof July 14, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Davis Memorial Cem.Location Old Town Rd.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.

19.

July 13 46 J. O. Frank
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12, 1946 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 11, 1946 to July 12, 1946and that I last saw alive on July 11, 1946Immediate cause of death Angina Pectoris DURATION 17 hrsDue to organic heart disease 5 yrsDue to ✓Other conditions ✓

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos. H. Evans M.D. M. D. or otherAddress Cumberland Md Date signed 7-13-46

RECEIVED

JUL 16 1946

BUREAU V B